Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

MEDICAID WAIVER ASSESSMENT

SECTION I – MEMBER DEMOGRAPHICS

Name *(last, first, middle)*	Date of birth *(mo., day, yr.)* / /		Medicaid number
Street address	County code	Sex *(check one)* ☐Male ☐Female	Marital status *(check one)* ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed
City, state and zip code	Emergency contact *(name)*		Emergency contact *(phone #)* ( ) -
Member phone number ( ) -	Is member able to read and write ☐Yes ☐No		Member's height Member's weight

SECTION II – MEMBER WAIVER ELIGIBILITY

Type of program applied for *(check one)* ☐ Home and Community Based Waiver ☐ Model Waiver II ☐ Acquired Brain Injury Waiver ☐ Supports for Community Living Waiver ☐ Consumer Directed Option ☐ Blended	Adjudicated /Nonadjudicated Type of application *(check one)* ☐ Certification ☐ Re-certification ☐ Re-application Rancho Scale _____
Member admitted from *(check one)* ☐Home ☐Hospital ☐Nursing facility ☐ ICF/MR/DD ☐Other_____	Certification period *(enter dates below)* Begin date / / End date / /
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form ☐Yes ☐No	Has member been informed of the process to make a complaint ☐Yes ☐No (*see instructions*)

Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number ( ) -

Enter member diagnosis(es): Primary:
Secondary:
Others:

AXIS I: AXIS II: AXIS III: AXIS IV: AXIS V:	Cause of Brain Injury: Date of Brain Injury: / /

SECTION III – ASSESSMENT PROVIDER INFORMATION

Assessment/Reassessment provider name:	Provider number	Provider phone number ( ) -
Street address	City, state and zip code	
Provider contact person		

Name *(last, first)*	**Medicaid Number**
SECTION IV – ACTIVITIES OF DAILY LIVING	
1) Is member independent with **dressing/undressing** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires total assistance	Comments:
2) Is member independent with **grooming** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues Requires hands-on assistance with ☐ oral care ☐shaving ☐ nail care ☐hair ☐ Requires total assistance	Comments:
3) Is member independent with **bed mobility** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Bed-bound ☐ Required bedrails	Comments:
4) Is member independent with **bathing** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires Peri-Care ☐ Requires total assistance	Comments:
5) Is member independent with **toileting** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Bladder incontinence ☐ Bowel incontinence ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Requires total assistance ☐ Bowel and bladder regimen	Comments:
6) Is member independent with **eating** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires assistance cutting meat or arranging food ☐ Partial/occasional help ☐ Totally fed (by mouth) ☐ Tube feeding (type and tube location)	Comments:

Name (last, first)	**Medicaid Number**
7) Is member independent with **ambulation** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Dependent on device ☐ Requires aid of one person ☐ Requires aid of two people ☐ History of falls (number of falls, and date of last fall)	Comments:
8) Is member independent with **transferring** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Hands-on assistance of one person ☐ Hands-on assistance of two people ☐ Requires mechanical device ☐ Bedfast	Comments:
SECTION V - INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
1) Is member able to prepare **meals** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for meal preparation ☐ Requires supervision or verbal cues ☐ Requires assistance with meal preparation ☐ Requires total meal preparation	Comments:
2) Is member able to **shop** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for shopping to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with shopping ☐ Unable to participate in shopping	Comments:
3) Is member able to perform light **housekeeping** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for light housekeeping duties to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with light housekeeping ☐ Unable to perform any light housekeeping	Comments:
4) Is member able to perform heavy **housework** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for heavy housework to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with heavy housework ☐ Unable to perform any heavy housework	Comments:

Name (last, first)	**Medicaid Number**
5) Is member able to perform **laundry** tasks ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for laundry to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with laundry tasks ☐ Unable to perform any laundry tasks	Comments:
6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of **medication(s)** and take them independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for medication to be obtained and taken correctly ☐ Requires supervision or verbal cues ☐ Requires assistance with obtaining and taking medication correctly ☐ Unable to obtain medication and take correctly	Comments:
7) Is member able to handle **finances** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for someone else to handle finances ☐ Requires supervision or verbal cues ☐ Requires assistance with handling finances ☐ Unable to handle finances	Comments:
8) Is member able to use the **telephone** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Requires adaptive device to use telephone ☐ Requires supervision or verbal cues ☐ Requires assistance when using telephone ☐ Unable to use telephone	Comments:
SECTION VI-MENTAL/EMOTIONAL	
1) Does member exhibit **behavior** problems ☐Yes ☐No *(If yes, check below all that apply and explain the frequency in comments)* ☐ Disruptive behavior ☐ Agitated behavior ☐ Assaultive behavior ☐ Self-injurious behavior ☐ Self-neglecting behavior	Comments: Date of functional analysis: / / and/or Date of behavior support plan: / /

Name (last, first)	**Medicaid Number**
2) Is the member diagnosed with one of the following: ☐Yes ☐No *(If yes, check below and comment)* ☐ Mental Retardation (Date-of-onset / /) ☐ Developmental Disability (Date-of-onset / /) ☐ Mental Illness (Date-of-onset / /) ☐ Substance Abuse (Date-of-onset / /)	Comments: **IQ Score**:
3) Is member **oriented** to person, place, time ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Forgetful ☐ Confused ☐ Unresponsive ☐ Impaired Judgment	Comments:
4) Has member experienced a major change or crisis within the past twelve months ☐Yes ☐No (*If yes, describe*)	Description:
5) Is the member actively participating in social and/or community activities ☐Yes ☐No (*If yes, describe*)	Description:
6) Is the member experiencing any of the following *(For each checked, explain the frequency and details in the comments section)* ☐Difficulty recognizing others ☐Loneliness ☐Sleeping problems ☐Anxiousness ☐Irritability ☐Lack of interest ☐Short-term memory loss ☐Long-term memory loss ☐Hopelessness ☐Suicidal behavior ☐Medication abuse ☐Substance abuse ☐ Alcohol Abuse	Comments:
SECTION VII-CLINICAL INFORMATION	
1) Is member's **vision** adequate *(with or without glasses)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply and comment)* ☐ Difficulty seeing print ☐ Difficulty seeing objects ☐ No useful vision	Comments:

Name (last, first)	**Medicaid Number**
2) Is member's **hearing** adequate *(with or without hearing aid)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply, and comment)* ☐ Difficulty with conversation level ☐ Only hears loud sounds ☐ No useful hearing	Comments:
3) Is member able to **communicate** needs ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Speaks with difficulty but can be understood ☐ Uses sign language and/or gestures/communication device ☐ Inappropriate context ☐ Unable to communicate	Comments:
4) Does member maintain an adequate **diet** ☐Yes ☐No *(If no, check all that apply and comment)* ☐ Uses dietary supplements ☐ Requires special diet (low salt, low fat, etc.) ☐ Refuses to eat ☐ Forgets to eat ☐ Tube feeding required *(Explain the brand, amount, and frequency in the comments section)* ☐ Other dietary considerations *(PICA, Prader-Willie, etc.)*	Comments:
5) Does member require **respiratory** care and/or equipment ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Oxygen therapy (Liters per minute and delivery device) ☐ Nebulizer (Breathing treatments) ☐ Management of respiratory infection ☐ Nasopharyngeal airway ☐ Tracheostomy care ☐ Aspiration precautions ☐ Suctioning ☐ Pulse oximetry ☐ Ventilator (list settings)	Comments:
6) Does member have history of a **stroke(s)** ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Residual physical injury(ies) ☐ Swallowing impairments ☐ Functional limitations (Number of limbs affected)	Comments:

Name (last, first)	**Medicaid Number**
7) Does member's **skin** require additional, specialized care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Requires additional ointments/lotions ☐ Requires simple dressing changes (i.e. band-aids, occlusive dressings) ☐ Requires complex dressing changes (i.e. sterile dressing) ☐ Wounds requiring "packing" and/or measurements ☐ Contagious skin infections ☐ Ostomy care	Comments:
8) Does member require routine lab work ☐Yes ☐No *(If yes, what type and how often)*	Comments:
9) Does member require specialized genital and/or urinary care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Management of reoccurring urinary tract infection ☐ In-dwelling catheter ☐ Bladder irrigation ☐ In and out catheterization	Comments:
10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) ☐Yes ☐No *(If yes, explain in the comments section)*	Comments:
11) Does member have total or partial paralysis ☐Yes ☐No *(If yes, list limbs affected and comment)*	Comments:
12) Does member require assistance with changes in body position ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ To maintain proper body alignment ☐ To manage pain ☐ To prevent further deterioration of muscle/joints/skin	Comments:

13) Does member require 24 hour caregiver ☐Yes ☐No
14) Does member require respite services ☐Yes ☐No *(If yes, how often)*

15) Does the member require intravenous fluids, intravenous medications or intravenous alimentation
☐Yes ☐No *(If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)*

☐ **Peripheral IV** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	

Name (last, first)		**Medicaid Number**	
☐ **Central line** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
16) Drug allergies *(list)*		**17)** Other allergies *(list)*	

18) Does the member use any medications ☐Yes ☐No *(If yes, list below)*

Name of medication	**Dosage/Frequency/Route**	**Administered by**

Name ***(last, first)***	**Medicaid Number**

19) Is any of the following adaptive equipment required *(If needs, explain in the comments)*

Dentures	☐Has	☐Needs	☐N/A
Hearing aid	☐Has	☐Needs	☐N/A
Glasses/lenses	☐Has	☐Needs	☐N/A
Hospital bed	☐Has	☐Needs	☐N/A
Bedpan	☐Has	☐Needs	☐N/A
Elevated toilet seat	☐Has	☐Needs	☐N/A
Bedside commode	☐Has	☐Needs	☐N/A
Prosthesis	☐Has	☐Needs	☐N/A
Ambulation aid	☐Has	☐Needs	☐N/A
Tub seat	☐Has	☐Needs	☐N/A
Lift chair	☐Has	☐Needs	☐N/A
Wheelchair	☐Has	☐Needs	☐N/A
Brace	☐Has	☐Needs	☐N/A
Hoyer lift	☐Has	☐Needs	☐N/A

Comments:

20) Please describe in detail any information regarding health, safety and welfare/crisis issues:

Name ***(last, first)***	**Medicaid Number**

SECTION VIII-ENVIRONMENT INFORMATION

1) Answer the following items relating to the member's physical environment *(Comment if necessary)*

Sound dwelling	☐Yes	☐No
Adequate furnishings	☐Yes	☐No
Indoor plumbing	☐Yes	☐No
Running water	☐Yes	☐No
Hot water	☐Yes	☐No
Adequate heating/cooling	☐Yes	☐No
Tub/shower	☐Yes	☐No
Stove	☐Yes	☐No
Refrigerator	☐Yes	☐No
Microwave	☐Yes	☐No
Telephone	☐Yes	☐No
TV/radio	☐Yes	☐No
Washer/dryer	☐Yes	☐No
Adequate lighting	☐Yes	☐No
Adequate locks	☐Yes	☐No
Adequate fire escape	☐Yes	☐No
Smoke alarms	☐Yes	☐No
Insect/rodent free	☐Yes	☐No
Accessible	☐Yes	☐No
Safe environment	☐Yes	☐No
Trash management	☐Yes	☐No

Comments:

2) Provide an inventory of home adaptations **<u>already present</u>** in the member's dwelling. *(Such as wheelchair ramp, tub rails, etc.)*

SECTION IX – HOUSEHOLD INFORMATION

1) Does the member live alone ☐Yes ☐No
If yes, does the member receive any assistance from others ☐Yes ☐No *(Explain)*

Comments:

Name ***(last, first)***	**Medicaid Number**

2)Household Members *(Fill in household member info below)*

a) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		

SECTION X-CONSUMER DIRECTED OPTION

1) Has the member chosen Consumer Direction Option? ☐Yes ☐No

SECTION XI-ADDITIONAL SERVICES

1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 6 months?
☐Yes ☐No *(If yes, please list below)*

a-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /
b-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /

Name ***(last, first)***	**Medicaid Number**

2) Does the member receive services from other agencies *(Example: Both Waiver and Non-waiver Services.)* ☐Yes ☐No *(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care)*

a-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units
c-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units

3) Is the member receiving traditional home health services ☐Yes ☐No *(If yes, list below all traditional home health services that are covered by Medicare/Medicaid/Third Party Insurance)*		Anticipated home health discharge date
a-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay
b-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay
c-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay

4) Summary for ***(check only one)*** ☐ Certification ☐ Amendment/Modification

Name ***(last, first)***	**Medicaid Number**
Signature: Date / /	
5) Provider performing assessment or reassessment:	
Signature: Title: Date / /	
Signature: Title: Date / /	
6)Verbal Level of Care Confirmation:	
Date: / /	Time: am/pm
7) Assessment/Reassessment forwarded to Support Broker/case management provider:	
Date Forwarded: / /	Time Forwarded: am/pm
Name of Person Forwarding:	Title of Person Forwarding:
8) Receipt of assessment/reassessment by Support Broker/case management provider:	
Date Received: / /	Time Received: am/pm
Name of Person Logging Receipt:	Title of Person Logging Receipt:

9) PRO Signature:	Date / /	Approval dates From: / / To: / /